

**NORTH CAROLINA COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL  
DISABILITIES AND SUBSTANCE ABUSE SERVICES**

**Advisory Committee Minutes  
Clarion Hotel  
320 Hillsborough Street  
Raleigh, NC**

**Thursday, October 16, 2008**

**Attending:**

**Commission Members:**

Marvin Swartz, MD, Dorothy Rose Crawford, John R. Corne, Dr. Diana J. Antonacci, Judith Ann Dempsey, Sandra C. DuPuy, Ranota Hall, M.D., Michael J. Hennike, Phillip A. Mooring, Dorothy O'Neal, John Owen, Don Trobaugh, Greg Olley, Ph.D.

**Ex-Officio Committee Members:**

Robin Huffman

**Excused:**

Norman Carter, Elizabeth MacMichael

**Division Staff:**

Steven E. Hairston, W. Denise Baker, Marta T. Hester, Andrea Borden, Tonya Goode, Amanda Reeder, Glenda K. Stokes, Michael Schwartz, John W. Harris, Carol Donin

**Others:**

Paula Cox Fishman, Louise G. Fisher, John L. Crawford, Joe Donovan, Susan Pollitt, Stephanie Alexander

**Handouts:**

- 1) DHHS Incident and Death Report (Form QM02)
- 2) Memorandum from Mike Moseley dated September 20, 2007 on Change in the DHHS Incident and Death Reporting Process Regarding Deaths Due to Unknown Causes
- 3) Division of MH/DD/SAS Policies and Procedures on Federal and State Death Reporting

**Call to Order:**

The meeting was called to order by Dr. Marvin Swartz, Chairman, Advisory Committee, at approximately 9:40am. Dr. Swartz welcomed the new members of the Advisory Committee, requested a moment of silence to replace the invocation, and issued the ethics awareness and conflict of interest reminder. He also excused Norman Carter and Elizabeth MacMichael from today's meeting.

*Upon motion, second, and unanimous vote, the Advisory Committee approved the minutes of the July 9, 2008 Advisory Committee Meeting.*

**Discussion of Session Law 2008-131, Senate Bill 1770 – Commission’s Reporting Requirement**

Dr. Swartz advised the Advisory Committee that the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services (NC DMH/DD/SAS) is charged with studying the current death reporting requirements under G.S. 122C-26(5)c. and assessing the need for any additional reporting requirements or modifications to existing rules or procedures. Following the Commission’s study, it must report its findings to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. He further added that although the legislation established a reporting deadline of November 1, 2008, John R. Corne, the Commission Chairperson, requested an extension until December 1, 2008.

Dr. Swartz also advised the Advisory Committee that its charge was to listen to the information being provided today in order to make recommendations to submit to the Full Commission at the November meeting. The Full Commission will then decide how to proceed in accordance with the requirements outlined in Session Law 2008-131, Senate Bill 1770. Mr. Corne further added that the Committee members should especially take note of which deaths are required to be reported, to whom they should be reported, and the actual reporting requirements.

**Review of Rules and Statutes which govern the Annual Death Reporting Requirements and the Annual Report on Consumer Deaths Reported and Facility Compliance with Restraint and Seclusion Policies and Procedures for State Fiscal Year 2007-2008**

Stephanie Alexander, Chief, Mental Health Licensure and Certification Section, NC Division of Health Service Regulation (NC DHSR), , began the presentation by discussing the reporting requirements under NC General Statute 122C-31, Report Required Upon Death of Client. NC General Statute 122C-31 states that *“A facility shall notify the Secretary immediately upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client, and shall notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide.”* Ms. Alexander also advised that deaths are reported to the NC Division of Health Service Regulation, Complaint Intake Unit. The determination regarding whether it is a reportable death is based on the General Statutes, which may result in its submission to the NC DHSR, Mental Health Licensure Unit and Disability Rights NC.

The following questions and comments were received from the Advisory Committee:

- Robin Huffman, Advisory Committee Ex-Officio Member, asked about the background of the employees within the NC DHSR, Complaint Intake Unit. Ms. Alexander advised that the unit is comprised of nurses, social workers, etc. and that each complaint is prioritized for investigation according to the seriousness of the situation and are investigated by the appropriate licensing section within the NC DHSR.
- John Owen, Advisory Committee member, stated that it is puzzling that a death resulting from an unknown cause is classified as a Level 2 incident because it could actually be a Level 3 incident. He further added that there is evidence of a cover up at Cherry Hospital and that he finds it disturbing that not enough cases are substantiated.
- Don Trobaugh, Advisory Committee Member, asked if any of the investigations were conducted by the NC State Bureau of Investigations and if there were any triggers that justify contacting the police for assistance. Ms. Alexander responded that some of the cases are coordinated with the local police and reported if there is any criminal involvement. She

further added that the surveyors within the NC DHSR, Complaint Intake Unit, go through six (6) months of training in order to know how to conduct surveys and investigations. Mr. Trobaugh asked whether the research and analytical skills of the surveyors required addressing and Ms. Alexander responded that it was not an issue since they were all highly qualified.

- Dr. Swartz inquired about whether the Advisory Committee members needed any additional information about federal rules as applicable to incident and death reporting.
- Judith Dempsey, Advisory Committee member, questioned if turnover issues within the NC DHSR, Complaint Intake Unit, is addressed by providing the new employees with training when they are initially hired. Ms. Alexander's response was positive.

Following Ms. Alexander's presentation, Carol Donin, Team Leader, NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, State Operated Services, provided an overview on the NC DMH/DD/SAS policies and procedures on federal and state death reporting. She noted that that the State-operated facilities must report all deaths regardless of cause.

Ms. Donin received the following questions and comments from the Advisory Committee:

- Dorothy Rose Crawford, Advisory Committee member, advised that it would be difficult for state-operated facilities to report all deaths because of the number of people dying along with their lack of knowledge of the deaths occurring.
- J. Michael Hennike, Advisory Committee member, advised that linkage to the local communities through discharge planning must be in place in order to comply with this reporting requirement. He questioned the three (3) day reporting period for deaths and recommended that the deaths should be reported within the same day in which they occurred. He also added that the Commission should address the continuity of care to ensure that reporting is established at both the state and community levels.
- Dr. Diana J. Antonacci questioned what mechanisms are in place to let facilities know about deaths in the community. She followed up by asking how the Division can be assured that all policies are being met. Ms. Donin responded that the Division is confident that all state facilities are aware of the established policies.
- Mr. Trobaugh asked Ms. Donin if she could provide the Commission with additional information to assist them in responding to the legislative reporting request. She shared that there is a gap between the discharge by the state facilities and the admission into the communities.
- In response to an inquiry from Dr. Antonacci, Stephanie Alexander from NC DHSR, provided more details regarding the investigation process. For example, if a death is investigated and determined to be unsubstantiated, DHSR can go back to revisit and reinvestigate the case, should additional information become available at a later date.
- Ms. Huffman asked if the Annual Report on Consumer Deaths Reported and Facility Compliance with Restraint and Seclusion Policies and Procedures for State Fiscal Year 2007-2008 submitted October 1, 2008 to the NC Joint Legislative Oversight Committee on Mental

Health, Developmental Disabilities and Substance Abuse Services, is based upon the previous legislative reporting guidelines. Both Ms. Donin and Ms. Alexander responded that was indeed the case.

- Mr. Hennike questioned the logic behind having different policies for licensed versus unlicensed facilities and inquired how that matters to consumers and family members. He also asked if the management of information differs. Ms. Alexander responded that others need to address that question instead of her and that there is not a mechanism which checks to ensure that all deaths are reported within the facilities.
- Mr. Corne stated that perhaps the reporting of all deaths should be examined and not just those in state-operated facilities.
- Ms. Donin provided clarification to the committee that while in July 2008, Session Law 2008-131 amended the general statutes to require all deaths in state-operated facilities to be reported to the medical examiners' office, this requirement only applies to facilities under General Statute 122C.
- Ms. Huffman asked about the Committee expanding this reporting requirement beyond state-operated facilities, similar to Mr. Corne's earlier question. Ms. Alexander reiterated that while legislation may not require the reporting of all deaths, it is a Division policy to report all deaths from unknown causes as required in a Memorandum from Mike Moseley, former Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, dated September 20, 2007.

Glenda Stokes, NC DMH/DD/SAS, Customer Services and Community Rights Team, gave the Committee a synopsis of community services and the death reporting requirements. According to Ms. Stokes, if an agency receives public funding, it must report all deaths. This requirement applies to both licensed and unlicensed facilities.

Ms. Stokes received the following questions and comments from the Advisory Committee:

- Dr. Greg Olley, Advisory Committee member, requested an example of an unlicensed services or facility. Ms. Stokes informed him that community support and private pay methadone programs would fit into this category.
- Sandra DuPuy, Advisory Committee member, expressed concern about the composition of the internal review teams in Rule 10A NCAC 27G .0603. When a Level 3 incident occurs, while the requirements exist for an investigation to occur by an internal review team, she advised that quite often in group homes the team consists of family members and friends. She is concerned about the impartiality and questioned why a Local Management Entity (LME) client rights person was not a part of the agency's internal review team. Dr. Ranota Hall agreed. Ms. Stokes explained that this step was in place to protect the immediate health and safety concerns and that later in the process, both the LMEs and the NC DMH/DD/SAS provide oversight.

### **Continued Discussion of Session Law 2008-131, Senate Bill 1770 – Commission’s Reporting Requirements**

The following comments and questions were received:

Mr. Trobaugh recommended that the Commission send forth the requirement that all deaths be reported within 24 hours from everyone. Dorothy O’Neal, Advisory Committee member, agreed. Both Mr. Owen and Dr. Olley advised that the investigations should be independent. Dr. Olley suggested that Disability Rights NC provide comments about the death reporting since the Secretary of the NC Department of Health and Human Services is required to report to that agency at the end of the reporting period. In response to this suggestion, Susan Pollitt, Attorney, Disability Rights NC, informed the Committee that there is a loophole in the General Statute and that all deaths should be reported, as well as, reported to their respective agencies. She further added that under General Statute 122C-10, an independent internal advisory system was created; however, it was never funded. Ms. Crawford expressed concern about the need of the state’s protective service law being updated. Ms. Dempsey questioned whether providers were required to have continuing education on the policies and procedures associated with death reporting and Stephanie Alexander responded no. Ms. DuPuy added that it is the providers’ responsibility to know what they are supposed to be doing.

Several of the members, Phillip A. Mooring, Dr. Swartz and Mr. Corne, proceeded to summarize the recommendations which the Committee members made during the day’s discussion, which are provided as follows:

- Consistency at different levels – people should have equal protection regardless of whether they are in a state or private facility
- More uniform Death Reporting and investigations
- Consistency of reporting with the same timeframe for reporting all deaths
- Closing Gaps
- Internal Review
- Independent review of deaths
- All Divisions involved work together to provide clarity and coordination of effort
- Death reporting should be required in NC General Statutes first, not the rules (the rules and policies should support the General Statute)

Following the conclusion of the discussion, Dr. Swartz advised the Advisory Committee that he will take the lead and summarize the recommendations from the day’s meeting. As the next step, these recommendations will be sent forward to the Full Commission to finalize in order to meet the reporting requirements outlined in Session Law 2008-131.

### **Assess to Healthcare: Veterans and Mental Health, Developmental Disabilities and Substance Abuse Services**

John Harris, Veterans Program Manager, NC DMH/DD/SAS, delivered a power point presentation to the Advisory Committee on veterans and their access and need for services in the areas of mental health, developmental disabilities and substance abuse. Mr. Harris informed the Committee that there are currently 792,646 veterans in the State of North Carolina. He also advised that both the headquarters of the U.S. Army Forces Command (“FORSCOM”) and the U.S. Army Reserve Command (“USARC”) are presently relocating to Fort Bragg, NC.

Following Mr. Harris’ presentation, Dr. Swartz read a statement from Norman Carter, an excused absent Advisory Committee member, regarding the inaccessibility and unavailability of

TRICARE to all veterans because of lack of coverage in all counties. Mr. Carter also raised concerns about the TBI Trust Fund and added that there is a great need for further TBI system development in the state. Mr. Harris acknowledged the concerns and stated that while the state legislature provided more money, it was not enough. He further reiterated that there is a significant need for a comprehensive assessment tool to be used in a program to help with the transition from military to civilian life.

#### **Finalize Priority Areas for 2008-09**

Dr. Swartz reviewed the recommendations the Advisory Committee had discussed previously as their priority areas for the current year. He also expressed the need to develop more work on the Workforce Development Initiative Plan and advised that it will be done at the next meeting in January 2009.

Dr. Antonacci suggested that TBI services should be added for consideration under the access to services category. Dr. Olley made the recommendation that people with developmental disabilities in the criminal justice system should also be added under the access to health care category.

#### **Public Comment**

Dr. Swartz informed the Committee that he will request input from the agency presenters to include in the Commission's legislative report. At the conclusion of the meeting, Commission Chairman Corne announced that ex-officios members will no longer sit on the Rules and Advisory Committees effective January 1, 2009; however, they are still encouraged to attend the meeting and provide input. He noted that there was no language within the General Statutes which allowed ex-officios.

#### **Adjournment**

**There being no further business, the Advisory Committee meeting adjourned at 2:00pm.**